New Jersey Department of Health and Senior Services

AMOEBIASIS REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race

☐ White ☐ American Indian ☐ Unknown/Other
☐ Black ☐ Asian

Ethnicity

☐ Hispanic ☐ Unknown
☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Possible ☐ Probable ☐ Confirmed

Intestinal amoebiasis? ☐ Yes ☐ No

If Yes: Diarrhea? ☐ Yes ☐ No Chills? ☐ Yes ☐ No

Fever? ☐ Yes ☐ No Abdominal discomfort? ☐ Yes ☐ No

Other symptoms: _____

Extraintestinal amoebiasis? ☐ Yes ☐ No

If Yes: Abscess of liver, lung, brain or other? ☐ Yes ☐ No

Please specify: _____

Laboratory Tests:

Stool examination? Date of Specimen Collection ____ / ____ / ____ ☐ Not done

If yes, describe results (or attach lab results): _____

Serological tests? Date of Specimen Collection ____ / ____ / ____ ☐ Not done

If yes, describe results (or attach lab results): _____

Radiological studies positive? ☐ Yes ☐ Not done Date of Result: ____ / ____ / ____

If yes, specify: _____

Tissue examination (biopsy)? ☐ Yes ☐ Not done Date of Result: ____ / ____ / ____

If yes, specify: _____

Was patient treated for amoebiasis? ☐ Yes ☐ No

Risk Factors:

Recent travel history? ☐ Yes ☐ No ☐ Unknown

If yes, when: _____

Where (country or state if outside of NJ): _____

Comments:

Name and Title of Person Submitting Report	Telephone Number

CDS-6
JAN 03